News and Views From the Literature

Sexuality

Testosterone and Sexual Desire

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[*Rev Obstet Gynecol.* 2009;2(1):65-66]

Treating Low Sexual Desire — New Findings for Testosterone in Women

Heiman JR.

N Engl J Med. 2008;359:2047-2049.

Testosterone for Low Libido in Postmenopausal Women Not Taking Estrogen

Davis SR, Moreau M, Kroll R, et al; for the APHRODITE Study Team.

N Engl J Med. 2008;359:2005-2017.

A woman must decide whether decreased desire poses a difficulty for her personally, in her intimate relationship, or, indeed, in her motivation to form or sustain such relationships. With more research being published, it is clear that many women value their sexuality well past menopause, and when circumstances curtail their enjoyment they are prepared to seek help.

The causes of less than optimal sexual function can be physiologic, due to aging, or psychologic, due to situations such as work, family, or medical problems affecting the woman or her partner. Medications such as serotonin reuptake inhibitors, β-blockers, or hormone replacement therapy (HRT) may affect libido, but, to date, most recommendations are toward psychosocial or couples therapy rather than pharmacologic agents.

Dr. Heiman, from the Kinsey Institute, believes that insufficient research funding has been allocated, and welcomes the work by Davis and colleagues as "all good news." A large cohort of postmenopausal women in 5 countries participated in a randomized trial of placebo versus 2 doses of transdermal testosterone to establish whether libido, arousal, and number of satisfying sexual episodes improved over 6 months. The active treatments were either 300 µg or 150 µg per day of testosterone. Patches were applied twice weekly to the abdomen (Intrinsa®; Proctor & Gamble Pharmaceuticals, Cincinnati, OH). No women were on HRT.

At the end of the trial, those using the 300-µg patches had significant improvement from baseline in the areas of desire, arousal, orgasm, and the number of pleasurable sexual episodes per month. There was a clear placebo effect, but the efficacy of the higher dose of the active

medication was still significant. Whether this "near doubling to 2" of episodes indicates a successful intervention must be up to women with depressed desire to decide.

Side effects were similar in the 3 groups, but there was a 20% increase in hair growth in the 300-µg group compared with 10% in the placebo group. A concern was that 4 of the 800 participants developed breast cancer over the year's surveillance—2 after 4 months of treatment and 1 whose disease probably predated the trial—and all received active treatment. Although possibly due to chance, a causal association must be considered.

The authors suggest these improvements are clinically valuable, offering relief for women with hypoactive sexual desire disorder and low serum estrogen levels.

Hormonal Contraception

The Effects of Hormonal Contraception

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Physiologic and Psychologic Symptoms Associated With Use of Injectable Contraception and 20-Microgram Oral Contraceptive Pills

Berenson AB, Odom SD, Breitkopf CR, Rahman M.
Am J Obstet Gynecol. 2008;199:351.e1-351.e12.

There are many claims made about the beneficial effects of hormonal contraceptives other than their ability to prevent pregnancy. Studies have tracked women's responses to oral contraceptives (OCs) or depot medroxyprogesterone acetate (DMPA), but few have taken into account the woman's entry status or baseline symptoms, and fewer still have looked at control groups on nonhormonal contraception. Another problem has been the duration of follow-up, which should be longer than 1 year to properly assess the steady state of a changed hormonal environment.

A study by Berenson and colleagues deals with the issues of baseline status and prolonged use in a series of women using injectable DMPA and low-dose OCs (typically 20 µg estrogen–containing pills).

The first important finding was that symptoms are common in the absence of contraceptive use, such as acne, cyclical mastalgia, cramping, and mood swings. They found these symptoms improved on sustained use of OCs compared with control groups, and there was no evidence that depression was a problem, despite lowered mood being a commonly quoted negative effect among those prescribing OCs.

The most frequent side effect was intermenstrual bleeding with OCs and an increased risk of bleeding for more than 20 days, amenorrhea, weight gain, and loss of energy and libido on DMPA. Most of these effects resolved after 6 months and almost all resolved by 12 months, with amenorrheaic women often welcoming the side effect.

Finally, the researchers found that women were not clearly informed of the potential side effects, or of their resolution with ongoing use. They recommend careful counseling about what to expect and more frequent follow-up after initiation to provide reassurance or a change to another method if required.

Hormonal Contraception and Bone Mineral Density

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Effects of Depot Medroxyprogesterone Acetate and 20-Microgram Oral Contraceptives on Bone Mineral Density

Berenson AB, Rahman M, Breitkopf CR, Bi LX.
Obstet Gynecol. 2008;112:788-799.

Hormonal contraceptives negatively affect bone mass density (BMD), but the effect is small and reversible. Low-dose OCs in young women are associated with less than 0.5% BMD loss in the hip and spine.

Berenson and colleagues also looked at BMD changes with DMPA and found up to a 5% loss. This is potentially significant in young women. They discovered that the effect was temporary and those who stopped using DMPA gained BMD at about 2.5% per year.